

# CONSTIPATION PROTOCOL

Name \_\_\_\_\_

The following is intended as a guideline. It does not supersede facility policy, nursing judgment, or physician orders.

## Call 911

The following could be signs of a Bowel Obstruction and need immediate attention!!

- If the person appears gravely ill or you are concerned about their immediate health and safety.
- If the person is vomiting material that smells like BM.
- If the person has severe, sharp intermittent or continuous abdominal pain
- If the person has a hard, protruding abdomen.
- Other \_\_\_\_\_

## Sign and Symptoms of Constipation/Impaction

- |  |   |
|--|---|
| <ul style="list-style-type: none"><li>• Hard, small, dry stools</li><li>• Bloating and gas</li><li>• Refusing to eat or drink</li><li>• Spending a lot of time on the toilet</li><li>• Straining or grunting</li><li>• Liquid runny stools</li></ul> | <ul style="list-style-type: none"><li>• Smears of feces in undergarments</li><li>• _____ days with no BM.</li><li>• Persons own way of letting you know they are constipated:</li><li>• _____</li><li>• _____</li></ul> |
|--|---|

If noted:

Notify the Nurse \_\_\_\_\_ Supervisor \_\_\_\_\_ Other \_\_\_\_\_  
Document on the Daily Notes \_\_\_\_\_ BM Record \_\_\_\_\_ MAR/TAR\* \_\_\_\_\_ Other \_\_\_\_\_

Documentation Reviewed by \_\_\_\_\_ Frequency of Review \_\_\_\_\_

\*MAR-Medication Administration TAR-Treatment Administration Record

## Normal Bowel Routine

Describe this persons normal frequency and consistency of BM's, when and where they normally go, and any special considerations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Monitoring

Document BM's on the \_\_\_\_\_ BM Record \_\_\_\_\_ MAR/TAR \_\_\_\_\_ Other \_\_\_\_\_  
BM's documented by \_\_\_\_\_ Observation \_\_\_\_\_ Self Report \_\_\_\_\_ Other \_\_\_\_\_  
Instructions on where to document when out of the home/at work: \_\_\_\_\_

Documentation Reviewed \_\_\_\_\_ Frequency of Review \_\_\_\_\_

**Treatment and Prevention**

Special interventions such as exercise, fluid recommendations. YES\_\_\_ NO\_\_\_ See MAR/TAR\_\_\_

Describe: \_\_\_\_\_

Dietary Supplements (Fruit Butter, Fiber) YES\_\_\_ NO\_\_\_ See MAR/TAR\_\_\_

Describe: \_\_\_\_\_

Toileting Schedule/Program YES\_\_\_ NO\_\_\_ See MAR/TAR\_\_\_

Describe: \_\_\_\_\_

Adaptive Equipment: (Elevated toilet seat, grab bars) YES\_\_\_ NO\_\_\_

Describe: \_\_\_\_\_

Adaptive positioning: (Stander, Prone Positioner, L or R sidelying) YES:\_\_\_ NO\_\_\_

Describe: \_\_\_\_\_

Mobility, clothing, equipment assistance: YES\_\_\_ NO\_\_\_

Describe: \_\_\_\_\_

Hygiene Assistance:(hand-over-hand washing, pericare) YES\_\_\_ NO\_\_\_

Describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Routine Medications** YES\_\_\_ NO\_\_\_ See MAR/TAR \_\_\_

**PRN Medications/Treatments** YES\_\_\_ NO\_\_\_ See MAR/TAR\_\_\_

Special Instructions for PRN meds: Such as when to administer ,how long to wait for results and who to notify if no results: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name \_\_\_\_\_

Completed by \_\_\_\_\_ Date \_\_\_\_\_

Review Dates \_\_\_\_\_

Adapted from Oregon Fatal Four Protocol  
Outreach Services of Indiana

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